Please type or print: Referred By: ______________________

Dr. ▢ Ms. ▢ Mr. ▢ Mrs. ▢

Last Name___________________________ First___________________________________ MI__

Address____

Home Phone________________ Business#_________________Cell#______________________

Fax____________________________________ E Mail__________________________________

Date of Birth____________________________ Social Sec. #______________________________

The best way to reach you: H#_______B#_______Cell#______E-Mail______Fax#______

PERSON RESPONSIBLE FOR ACCOUNT (If other than patient)

Dr. ▢ Ms. ▢ Mr. ▢ Mrs. ▢

Last Name_____________________________First________________________ MI_____

Address____

Soc. Sec. #_____________________________

NOTIFY IN CASE OF EMERGENCY

(Someone who does not live with you)

Last Name____________________________ First________________________ MI_____

Home#________________________________ Business #___________________________

Relationship to Patient____

Office Procedures:

Appointments: Once an appointment is made, please remember that the time has been reserved for you. A charge will be made for failed or canceled appointments without prior notification of 24 hours.

I understand that any photographs, slides and/or video pictures taken of me may be used for educational purposes.

Insurance: To avoid any misunderstanding regarding dental insurance, we want you to know that all professional services rendered are charged directly to the patient and that patients are personally responsible for payment of fees. We will assist you in preparing necessary forms to help you obtain your benefits from insurance companies. We do not render our services on the basis that insurance companies will pay all our fees. Each fee is individual to the individual patient.

Fees: Due to the increased cost of mailing statements and in trying to keep our fees as low as possible, we expect our patients to pay for services at the time they are received. Accounts not paid within thirty days may be subject to an interest charge of 1.5% per month (annual rate of 18%) unless other arrangements are made with our office.

Signed____ Date__________________
(Parent, if patient is a minor)

Medical History

Name____

Family Physician_______________________Specialty_______________ Phone_______________

Additional Physician____________________Specialty_______________ Phone_______________

Height_________Weight________Age______Last Complete Medical Exam___________________

Please Check Y for Yes or N for No

		Yes	No			Yes	No			Yes	No
1.	Medical Problem	☐	☐	14.	Stroke	☐	☐	27.	Major Operation	☐	☐
2.	Heart Ailment	☐	☐	15.	Diabetes	☐	☐	28.	Serious Accident	☐	☐
3.	Heart Murmur	☐	☐	16.	Fainting/Dizziness	☐	☐	29.	HIV +/AIDS	☐	☐
4.	Rheumatic Fever	☐	☐	17.	Insomnia	☐	☐	30.	Change in Weight	☐	☐
5.	High/Low Blood Pressure	☐	☐	18.	Nervous Disorder	☐	☐	31.	Easily Fatigued	☐	☐
6.	Thyroid Problems	☐	☐	19.	Asthma/Hayfever	☐	☐	32.	Ulcers	☐	☐
7.	MVProlapse	☐	☐	20.	Tuberculosis	☐	☐	33.	Cough	☐	☐
8.	Shortness of Breath	☐	☐	21.	Hepatitis	☐	☐	34.	Communicable Disease	☐	☐
9.	Swollen Ankles	☐	☐	22.	Arthritis	☐	☐	35.	Liver Problem	☐	☐
10.	Anemia	☐	☐	23.	Tumor/Cancer	☐	☐	36.	Kidney Problem	☐	☐
11.	Headaches	☐	☐	24.	Excessive Bleeding	☐	☐	37.	Psychiatric Treatment	☐	☐
12.	Supervised Diet	☐	☐	25.	Prosthetic Implant	☐	☐	38.	Drug Dependency	☐	☐
13.	Alcohol Dependency	☐	☐	26.	Tobacco Dependency	☐	☐	39.	Medication Allergies	☐	☐

Women:		Yes	No	
	1.Pregnant?	☐	☐	If yes, Month____________
	2.Menopause?	☐	☐	If yes, Supportive Medication___________

If yes, please explain: (by number)

____

____

____

List all medications (include aspirin, sleeping medication, weight loss medication, sedative)

Taking:_____________________________ For:________________________________

Taking:_____________________________ For:________________________________

Taking:_____________________________ For:________________________________

Taking:_____________________________ For:________________________________

	Yes	No
Have you ever had a bad reaction to a dental anesthetic?	☐	☐
Are you allergic to latex?	☐	☐
Have you ever taken Phen-fen or any weight loss medication?	☐	☐
Do you need to be premedicated with antibiotics before dental treatment?	☐	☐

Medication____

Are there any medical concerns or life style situations that you would like to discuss?____

Signed____ Date_______________

HIPAA Privacy Notice

THIS NOTICE DESCRIBES HOW MEDICAL AND DENTAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

INTRODUCTION

We are required by law to maintain the privacy of "protected health information". "Protected Health Information" includes any identifiable information that we obtain from you or others that relates to your physical or mental health, the health care you have received, or payment for your health care.

As required by law, this notice provides you with information about your rights and our legal duties and privacy practices with respect to the privacy of protected health information. This notice also discusses the uses and disclosures we will make of your protected health information.

We may change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain at that time. We will provide you with any Revised Notice of Privacy Practices at the time of your next appointment.

PERMITTED USES AND DISCLOSURES

As provided by law, we can use or disclose your protected health information for purposes of *treatment, payment and health care operations*. If you refuse to consent, we do not have to provide you with non-emergency care.

- *Treatment* means the provision, coordination or management of your health care, including consultations between health care providers regarding your care and referrals for health care from one health care provider to another. For example, your protected health information may be provided to a health care provider who referred you to our practice to ensure that the provider has all of your medical/dental information.

- *Payment* means activities we undertake to obtain reimbursement for the health care provided to you, including determinations of eligibility and coverage and utilization review activities. For example, prior to providing health care services, we may need to provide to your insurance company information about your medical/dental condition to determine whether the proposed course of treatment will be covered. When we subsequently bill the insurance company for the services rendered to you, we can provide the insurance company with information regarding your care, if necessary, to obtain payment.

- *Health care operations* means the support functions of our practice related to *treatment and payment,* such as quality assurance activities, case management, receiving and responding to patient complaints, physician reviews, compliance programs, audits, business planning, development, management and administrative activities. For example, we may use your medical/dental information to evaluate the performance of our staff when caring for you. We may also combine medical/dental information about many patients to decide what additional services we should offer, what services are not needed, and whether certain new treatments are effective. Furthermore, any photography, slides, video pictures and/or models may be used for educational purposes, as well as, to discuss treatment with other specialists.

OTHER USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

When we determine, in our professional judgment, that it is in your best interest, we may disclose your protected health information to your family or friends when they are involved in your care or the payment of your care. We will only disclose the protected health information directly relevant to their involvement in your care or payment.

We will allow your family and friends to act on your behalf to pick up filled prescriptions, medical supplies, x-rays and similar forms of protected health information, when we determine, in our professional judgment, that it is in your best interest to make such disclosures.

We will share your protected health information with third party "business associates" that perform various activities (e.g., answering service) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health insurance information in the following situations without your consent or authorization. These situations include:

- *Required By Law:* We may use or disclose your protected health information to the extent that law requires the use of disclosure. The use of disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

- *Public Health:* We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

- *Communicable Diseases:* We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

- *Health Oversight:* We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system government benefit programs, other government regulatory programs and civil right laws.

- *Abuse or Neglect:* We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

- *Food and Drug Administration:* We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products to enable product recalls, make repairs or replacement, or to conduct post marketing surveillance as required.

- *Legal Proceedings:* We may disclose protected health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request, or other lawful process.

- *Law Enforcement:* We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include: 1) legal processes otherwise required by law; 2) limited information requests for identification and location purposes pertaining to victims of a crime; 3) suspicion that death has occurred as a result of criminal conduct; 4) request for information in the event that a crime occurs on the premises of the practice; and 5) medical emergency (not on practice's premises) and it is likely that a crime has occurred.

- *Military Activity and National Security:* When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel: 1) for activities deemed necessary by the appropriate military command authorities; 2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits; 3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including the provision of protective services to the President or others legally authorized.

Except for the general uses and disclosures described above, we will not use or disclose your protected health information for any other purpose unless you provide a written authorization. You have the right to revoke that authorization at any time, provided that the revocation is in writing, except to the extent that we already have taken action in reliance on your authorization.

Your Rights

1. You have the right to request restrictions on our uses and disclosures of protected health information for treatment, payment and health care operations. However, we are not required to agree to your request.

2. You have the right to reasonable request to receive communications of protected heath information by alternative means or at alternative locations.

3. You have the right to inspect and copy the protected health information contained in your dental and billing records and in any other practice records used by us to make decisions about you.

4. You have the right to request and receive a paper copy of this notice from us.

COMPLAINTS

If you believe that your privacy rights have been violated, you should immediately contact the practice manager at our practice. We will not take action against you for filing a complaint. You also may file a complaint with the Secretary of Health and Human Services.

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge receipt of the Office Procedures and HIPPA policy as well as the accuracy of my medical and dental history to the best of my knowledge:

Signature: ____ Date: _______________
(Parent, if patient is a minor)